# General

## Guideline Title

Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas.

## Bibliographic Source(s)

National Institute for Health and Clinical Excellence (NICE). Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Mar. 116 p. (Clinical guideline; no. 118). [73 references]

## Guideline Status

This is the current release of the guideline.

# Recommendations

## Major Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the Centre for Clinical Practice at the National Institute for Health and Clinical Excellence (NICE).

Throughout this guideline, the term 'adenomas' is used. However, other terms have been used in the clinical studies included in the evidence review, for example 'polyps' or 'adenomatous polyps'.

People with Inflammatory Bowel Disease

Offer colonoscopic surveillance to people with inflammatory bowel disease (IBD) whose symptoms started 10 years ago and who have:

- Ulcerative colitis (but not proctitis alone) or
- Crohn's colitis involving more than one segment of colon

Offer a baseline colonoscopy with chromoscopy and targeted biopsy of any abnormal areas to people with IBD who are being considered for colonoscopic surveillance to determine their risk of developing colorectal cancer (see Table 1 below).

| Table 1: Risk of Developing Colorectal Cancer in People with IBD |
| --- |
| Low risk:<br>• Extensive but quiescent ulcerative colitis or |

Table 1: Risk of Developing Colorectal Cancer in People with IBD

- Extensive but quiescent Crohn's colitis or
- Left-sided ulcerative colitis (but not proctitis alone) or Crohn's colitis of a similar extent

Intermediate risk:

- Extensive ulcerative or Crohn's colitis with mild active inflammation that has been confirmed endoscopically or histologically or
- Post-inflammatory polyps or
- Family history of colorectal cancer in a first-degree relative aged 50 years or over

High risk:

- Extensive ulcerative or Crohn's colitis with moderate or severe active inflammation that has been confirmed endoscopically or histologically or
- Primary sclerosing cholangitis (including after liver transplant) or
- Colonic stricture in the past 5 years or
- Any grade of dysplasia in the past 5 years or
- Family history of colorectal cancer in a first-degree relative aged under 50 years

Offer colonoscopic surveillance to people with IBD as defined in the recommendation above based on their risk of developing colorectal cancer (see Table 1 above), determined at the last complete colonoscopy:

- Low risk: offer colonoscopy at 5 years.
- Intermediate risk: offer colonoscopy at 3 years.
- High risk: offer colonoscopy at 1 year.

For people with IBD who have been offered colonoscopic surveillance, continue to use colonoscopy with chromoscopy as the method of surveillance.

Offer a repeat colonoscopy with chromoscopy if any colonoscopy is incomplete. Consider whether a more experienced colonoscopist is needed.

People with Adenomas

Consider colonoscopic surveillance for people who have had adenomas removed and are at low risk of developing colorectal cancer (see Table 2 below).

Offer colonoscopic surveillance to people who have had adenomas removed and are at intermediate or high risk of developing colorectal cancer (see Table 2 below).

Use the findings at adenoma removal to determine people's risk of developing colorectal cancer (see Table 2 below).

Table 2: Risk of Developing Colorectal Cancer in People with Adenomas

Low risk:

- One or two adenomas smaller than 10 mm

Intermediate risk:

- Three or four adenomas smaller than 10 mm or
- One or two adenomas if one is 10 mm or larger

High risk:

- Five or more adenomas smaller than 10 mm or
- Three or more adenomas if one is 10 mm or larger

Offer the appropriate colonoscopic surveillance strategy to people with adenomas based on their risk of developing colorectal cancer as determined at initial adenoma removal (see Table 2 above).

Low risk: consider colonoscopy at 5 years:

- If the colonoscopy is negative (that is, no adenomas are found) stop surveillance.
- If low risk, consider the next colonoscopy at 5 years (with follow-up surveillance as for low risk).
- If intermediate risk, offer the next colonoscopy at 3 years (with follow-up surveillance as for intermediate risk).
- If high risk, offer the next colonoscopy at 1 year (with follow-up surveillance as for high risk).

Intermediate risk: offer colonoscopy at 3 years:

- If the colonoscopy is negative, offer the next colonoscopy at 3 years. Stop surveillance if there is a further negative result.
- If low or intermediate risk, offer the next colonoscopy at 3 years (with follow-up surveillance as for intermediate risk).
- If high risk, offer the next colonoscopy at 1 year (with follow-up surveillance as for high risk).

High risk: offer colonoscopy at 1 year:

- If the colonoscopy is negative, or low or intermediate risk, offer the next colonoscopy at 3 years (with follow-up surveillance as for intermediate risk).
- If high risk, offer the next colonoscopy at 1 year (with follow-up surveillance as for high risk).

Offer a repeat colonoscopy if any colonoscopy is incomplete. Consider whether a more experienced colonoscopist is needed.

Consider computed tomographic colonography (CTC) (see Computed tomographic colonography [virtual colonoscopy]. NICE interventional procedure guidance 129 [2005] ) as a single examination if colonoscopy is not clinically appropriate (for example, because of comorbidity or because colonoscopy cannot be tolerated).

Consider double contrast barium enema as a single examination if CTC is not available or not appropriate.

Consider CTC or double contrast barium enema for ongoing surveillance if colonoscopy remains clinically inappropriate, but discuss the risks and benefits with the person and their family or carers.

Providing Information and Support

Discuss the potential benefits, limitations and risks with people who are considering colonoscopic surveillance including:

- Early detection and prevention of colorectal cancer and
- Quality of life and psychological outcomes

Inform people who have been offered colonoscopy, CTC, or barium enema about the procedure, including:

- Bowel preparation
- Impact on everyday activities
- Sedation
- Potential discomfort
- Risk of perforation and bleeding

After receiving the results of each surveillance test, discuss the potential benefits, limitations and risks of ongoing surveillance. Base a decision to stop surveillance on potential benefits for the person, their preferences and any comorbidities. Make the decision jointly with the person, and if appropriate, their family or carers.

If there are any findings at surveillance that need treatment or referral, discuss the options with the person, and if appropriate, their family or carers.

Throughout the surveillance programme, give the person and their family or carers the opportunity to discuss any issues with a healthcare professional. Information should be provided in a variety of formats tailored to the person's needs and should include illustrations.

## Clinical Algorithm(s)

Care pathways for people with inflammatory bowel disease (IBD) and people with adenomas are provided in the original guideline document.

# Scope

## Disease/Condition(s)

- Colorectal cancer
- Inflammatory bowel disease (ulcerative colitis and Crohn's disease)
- Adenomas (polyps, adenomatous polyps)

## Guideline Category

Counseling

Prevention

Risk Assessment

Screening

## Clinical Specialty

Colon and Rectal Surgery

Family Practice

Gastroenterology

Internal Medicine

Oncology

Preventive Medicine

Radiology

## Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Health Plans

Hospitals

Managed Care Organizations

Nurses

Patients

Physician Assistants

Physicians

## Guideline Objective(s)

To offer best practice advice on the use of colonoscopic surveillance in adults with inflammatory bowel disease (IBD, which covers ulcerative colitis and Crohn's disease) or adenomas

## Target Population

- Adults (18 years and older) with IBD (defined as ulcerative colitis or Crohn's disease involving the large bowel)
- Adults with polyps (including adenomas) in the colon or rectum

Note: The following groups are not covered in this guideline:

Children (younger than 18 years)
Adults with newly diagnosed or relapsed adenocarcinoma of the colon or rectum
Adults with polyps that have previously been treated for colorectal cancer
Adults with a genetic familial history of colorectal cancer: hereditary non-polyposis colorectal cancer
Adults with a familial history of polyposis syndromes: familial adenomatous polyposis

## Interventions and Practices Considered

1. Colonoscopic surveillance using conventional colonoscopy or chromoscopy and targeted biopsy
2. Initiation of surveillance and the frequency of ongoing surveillance (considering risk factors including duration and extent of condition, number, size and location of polyps)
3. Surveillance using other methods, such as double-contrast barium enema and computed tomographic colonography
4. Providing information and support for people undergoing or considering undergoing colonoscopic surveillance

Note: The following were considered but not recommended: flexible sigmoidoscopy and tri-modal imaging.

## Major Outcomes Considered

- Progression to colorectal cancer
- Stage at presentation
- Progression or regression of dysplasia at most recent follow-up of inflammatory bowel disease
- Overall mortality or survival
- Reported adverse effects of colonoscopic surveillance techniques
- Health-related quality of life (related to colonoscopic surveillance)
- Resource use and costs

# Methodology

## Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Searches of Electronic Databases

## Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the Centre for Clinical Practice at the National Institute for Health and Clinical Excellence (NICE).

Scoping Searches

Scoping searches were undertaken in September 2009; browsing or simple search strategies were employed. The search results were used to

provide information for scope development and project planning. (See Appendix 5 in the original guideline for list of websites and databases.)

Main Searches

The following sources were searched for the topics presented in the sections below.

- Cochrane Database of Systematic Reviews – CDSR (Wiley)
- Cochrane Central Register of Controlled Trials – CENTRAL (Wiley)
- Database of Abstracts of Reviews of Effects – DARE (CRD Databases)
- Health Technology Assessment Database HTA (CRD Databases)
- CINAHL (EBSCO and NHS Evidence – Search 2.0)
- EMBASE (Ovid)
- MEDLINE (Ovid)
- MEDLINE In-Process (Ovid)
- PSYCINFO (Ovid)

The searches were conducted in November 2009. The aim of the searches was to provide evidence on colonoscopic surveillance (using conventional colonoscopy or chromoscopy) for prevention and early detection of colorectal cancer compared with no surveillance. Search filters for systematic reviews, randomised controlled trials, and observational studies were appended to the search strategies to retrieve high quality papers. Refer to Appendix 5 of the original guideline for details of the search strategies, including specific terms used for all of the searches.

*Identification of Evidence on Surveillance Using Other Methods*

The searches were conducted in November 2009. The aim of the searches was to provide evidence on colonoscopic surveillance (using conventional colonoscopy or chromoscopy) for prevention and early detection of colorectal cancer compared with surveillance using other methods, such as flexible sigmoidoscopy, double-contrast barium enema, computed tomographic colonography, and tri-modal imaging (high resolution white light endoscopy, narrow-band imaging and auto-fluorescence imaging).

*Identification of Evidence on the Information and Support Needs of People Undergoing or Considering Undergoing Colonoscopic Surveillance*

The searches were conducted in December 2009. The aim of the searches was to provide evidence on the information and support needs of people undergoing or considering undergoing colonoscopic surveillance.

*Identification of Systematic Reviews, Randomised Controlled Trials, and Observational Studies*

Search filters for systematic reviews, randomised controlled trials, and observational studies were appended to the search strategy on identification of evidence on colonoscopic surveillance (and evidence on surveillance using other methods above to retrieve high quality evidence).

Health Economics

The following sources were searched to identify economic evaluations and quality of life data relating to colonoscopic surveillance (using conventional colonoscopy or chromoscopy) for prevention and early detection of colorectal cancer compared with no surveillance

- Health Economic Evaluations Database – HEED (Wiley)
- National Health Service Economic Evaluation Database – NHS EED (Wiley and CRD website)
- EMBASE (Ovid)
- MEDLINE (Ovid)
- MEDLINE In-Process (Ovid)

The searches were undertaken in November 2009. Filters to retrieve economic evaluations and quality of life papers were appended to the MEDLINE search strategy to identify relevant evidence. Refer to Appendix 5 of the original guideline for details of the search strategies, including specific search terms used.

## Number of Source Documents

Not stated

## Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus (Committee)

## Rating Scheme for the Strength of the Evidence

Not applicable

## Methods Used to Analyze the Evidence

Meta-Analysis

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

## Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the Centre for Clinical Practice at the National Institute for Health and Clinical Excellence (NICE).

'Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease and adenomas' is a NICE short clinical guideline. For a full explanation of how this type of guideline is developed, see 'The guidelines manual' (2009) (see the "Availability of Companion Documents" field).

The eligibility criteria for including studies were developed with the help of the Guideline Development Group using a questionnaire (see appendix 3 of the original guideline document). For this guideline, colonoscopic surveillance was considered as an intervention. The results from the included studies are presented in 'Grading of recommendations, assessment, development and evaluation' (GRADE) profiles and evidence statements. GRADE profiles were modified to allow for evidence from both randomised controlled trials (RCTs) and observational studies to be presented together for the same outcomes.

For each review question, the evidence sections are split. The evidence for people with inflammatory bowel disease (IBD) is presented first in the original guideline document, followed by the evidence for people with adenomas.

Evidence tables are provided in appendix 6 of the full version of the original guideline document.

## Methods Used to Formulate the Recommendations

Expert Consensus

## Description of Methods Used to Formulate the Recommendations

Note from the National Guideline Clearinghouse (NGC): This guideline was developed by the Centre for Clinical Practice at the National Institute for Health and Clinical Excellence (NICE).

Forming and Running the Short Clinical Guideline Development Group (GDG)

Each short clinical guideline is developed by a unique GDG consisting of 10–12 members, supported by the Short Clinical Guidelines Team. Each GDG has a Chair, healthcare professional members and a minimum of two patient and carer members. Co-opted expert advisers are recruited, as appropriate. A Clinical Adviser, who has specific content expertise and additional responsibilities, may also be appointed depending on the topic. Recruitment of the GDG Chair and members is carried out in accordance with NICE's policy.

The GDG makes its decisions using the best available evidence presented to it at GDG meetings by the Short Clinical Guidelines Team. The use of formal consensus methods within the GDG will be considered on a case-by-case basis.

Developing Review Questions

A short clinical guideline has a narrow scope and covers only part of a care pathway. It addresses a maximum of three subject areas covering clinical management. This will result in a small number of key clinical issues. These are broken down into a defined number of review questions — usually one or two per clinical management area. The exact number will be dictated by the size of the short clinical guideline remit and the amount of development time available.

Creating Guideline Recommendations

Explicit methods of linking the evidence to recommendations are used for short clinical guidelines if the topic is suitable. This involves using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach.

Research recommendations are formulated for short clinical guidelines. Their number is dependent on the size of the short clinical guideline remit and the amount of development time available.

Writing the Guideline

There are usually three versions of short clinical guidelines:

- The full guideline – all the recommendations, details of how they were developed and summaries of the evidence they are based on.
- The quick reference guide – a summary of the recommendations for healthcare professionals.
- 'Understanding NICE guidance' – a summary for patients and carers.

The full guideline is written by the Short Clinical Guidelines Team, following the principles in chapters 9 and 10 of 'The guidelines manual' (see the "Availability of Companion Documents" field).

## Rating Scheme for the Strength of the Recommendations

Not applicable

## Cost Analysis

The economic evidence identified by the health economics systematic review is summarised in the respective chapters of the full version of the guideline, following presentation of the clinical evidence. Methods and results of economic modelling are reported in the economic sections of the respective evidence chapters.

The full results of the cost-effectiveness analysis are detailed in Appendix 7 and 8 of the original guideline document (see the "Availability of Companion Documents" field).

## Method of Guideline Validation

External Peer Review

Internal Peer Review

## Description of Method of Guideline Validation

The guideline was validated through two consultations.

1. The first draft of the guideline (National Institute for Health and Clinical Excellence [NICE] guideline and Quick Reference Guide) were consulted with Stakeholders and comments were considered by the Guideline Development Group (GDG)
2. The final consultation draft of the NICE guideline and the Information for the Public were submitted to stakeholders for final comments.

The final draft was submitted to the Guideline Review Panel for review prior to publication.

# Evidence Supporting the Recommendations

## Type of Evidence Supporting the Recommendations

The type of supporting evidence is not specifically stated for each recommendation.

# Benefits/Harms of Implementing the Guideline Recommendations

## Potential Benefits

Colonoscopic surveillance in people with inflammatory bowel disease (IBD) or adenomas can detect any problems early and potentially prevent progression to colorectal cancer.

## Potential Harms

Complications of colonoscopy:

- Risk of perforation and bleeding
- Potential discomfort
- Polypectomy syndrome

# Qualifying Statements

## Qualifying Statements

- This guidance represents the view of the National Institute for Health and Clinical Excellence (NICE), which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.
- Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

# Implementation of the Guideline

## Description of Implementation Strategy

An implementation strategy was not provided.

## Implementation Tools

Audit Criteria/Indicators

Clinical Algorithm

Foreign Language Translations

Patient Resources

Quick Reference Guides/Physician Guides

Resources

Slide Presentation

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

# Institute of Medicine (IOM) National Healthcare Quality Report Categories

## IOM Care Need

Living with Illness

Staying Healthy

## IOM Domain

Effectiveness

Patient-centeredness

# Identifying Information and Availability

## Bibliographic Source(s)

National Institute for Health and Clinical Excellence (NICE). Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Mar. 116 p. (Clinical guideline; no. 118). [73 references]

## Adaptation

Not applicable: The guideline was not adapted from another source.

## Date Released

2011 Mar

## Guideline Developer(s)

National Institute for Health and Care Excellence (NICE) - National Government Agency [Non-U.S.]

## Source(s) of Funding

National Institute for Health and Clinical Excellence (NICE)

## Guideline Committee

Guideline Development Group

## Composition of Group That Authored the Guideline

*Guideline Development Group Members*: Peter Howdle, Emeritus Professor and Chair of the Guideline Development Group; Wendy Atkin, Professor of Epidemiology, Imperial College London, (GDG member February–July 2010); Matthew Rutter, Consultant Gastroenterologist, University Hospital of North Tees; Janusz Jankowski, Professor of Gastroenterology, University Hospitals of Leicester NHS Trust; Bruce Fox, Consultant Gastrointestinal Radiologist, Derriford Hospital, Devon; Carol Makin, Consultant General and Colorectal Surgeon, Wirral University Teaching Hospital; Julie D'Silva, Consultant Endoscopist, Clinical Lead for Quality Assurance, Endoscopy Services, Rotherham General Hospital NHS Trust; Marco Novelli, Professor of Histopathology, University College Hospital NHS Foundation Trust London; Tracey Cole, Patient member; Elaine Trump, Patient member

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## Financial Disclosures/Conflicts of Interest

A full list of all declarations of interest made by this Guideline Development Group is available on the NICE website (www.nice.org.uk ).

## Guideline Status

This is the current release of the guideline.

## Guideline Availability

Electronic copies: Available from the National Institute for Health and Clinical Excellence (NICE) Web site .

## Availability of Companion Documents

The following are available:

- Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Mar. 6 p. (Clinical guideline; no. 118). Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site .
- Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas. Appendices. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Mar. Various p. (Clinical guideline; no. 118). Electronic copies: Available in PDF from the NICE Web site .
- Colonoscopic surveillance overview. NICE pathways. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Nov. (Clinical guideline; no. 118). Electronic copies: Available from the NICE Web site .
- Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas. Audit support. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011. 11 p. (Clinical guideline; no. 118). Electronic copies: Available from the NICE Web site .
- Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas. Baseline assessment tool. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011. (Clinical guideline; no. 118). Electronic copies: Available from the NICE Web site .
- Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas. Costing

statement. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Mar. 7 p. (Clinical guideline; no. 118). Electronic copies: Available in PDF from the NICE Web site .

- Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas. Costing template. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Mar. (Clinical guideline; no. 118). Electronic copies: Available from the NICE Web site .
- Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas. Slide set. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Mar. 29 p. (Clinical guideline; no. 118). Electronic copies: Available from the NICE Web site .
- The guidelines manual 2009. London (UK): National Institute for Health and Clinical Excellence (NICE); 2009 Jan. Electronic copies: Available in PDF from the NICE Archive Web site .

## Patient Resources

The following is available:

- Surveillance of the large bowel: preventing cancer in people at risk. Understanding NICE guidance. Information for people who use NHS services. London (UK): National Institute for Health and Clinical Excellence (NICE); 2011 Mar. 8 p. (Clinical guideline; no. 118). Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site . Also available in Welsh from the NICE Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

## NGC Status

This NGC summary was completed by ECRI Institute on January 31, 2012.

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